DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC 2

PRINTED: 12/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445314	A. BUILDING _____ B. WING _____	C 12/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MORRISTOWN	501 WEST ECONOMY ROAD MORRISTOWN, TN 37814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of facility investigation documentation and interview, the facility failed to implement policies and procedures to prevent misappropriation of narcotic medications for eight residents (#1 - #8) of eleven sampled residents. The findings included: Review of facility policy revealed, "...Reporting...All (facility) personnel are mandated to promptly report suspected resident abuse and/or neglect to their immediate supervisor...All alleged or suspected violations involving mistreatment, abuse, neglect...will be promptly reported to the administrator and/or director of nursing..." Review of facility investigation documentation dated November 14, 2011, revealed, ,"...Audit was performed and the card for these medications was found empty in a locked cabinet to which only one person had access to...Further investigation...determined that there were also empty narcotic cards for the following residents: (#1-#8)...Conclusion is presumable medications	F224 CORRECTIVE ACTION: All residents proven to be involved in this incident were either discharged from facility, expired or medications were discontinued. Appropriate compensation to residents (all were discharged or in the hospital) cited in deficiencies for misappropriation of medication. (01-05-12). Education was provided (11-15-11) to all licensed nursing about the expectation of prompt reporting of any suspicions event, situation or occurrence toward a resident F224 RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents utilizing narcotics have the potential to be affected. F224 SYSTEMATIC CHANGES: Continued education to facility associates of the facility abuse policy, review of types of abuse, infringement, misappropriation of residents rights or property, prompt and appropriate reporting of suspicions to immediate supervisor and/or administration will occur upon hire, quarterly and as needed. All residents will continue to have monthly review of Resident Rights in Resident Council. Random audits of staff (10% of licensed nursing associates) will be conducted to check knowledge of abuse policy, specific to misappropriation weekly times four weeks then monthly thereafter (started 12-27-11).	11-15-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kellie Coste Hensley
TITLE: Executive Director
(X6) DATE: 01/09/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1 of discharged residents, discontinued narcs (narcotics) have gone missing from facility..." Continued review revealed the following: Resident #1: "...Percocet 5-325 mg (milligrams)...Amount Missing 28 pills..." Resident #2: "...Morphine Sulfate 15 mg...Amount Missing 9 pills..." Resident #3: "...Oxycodone Solution...Amount Missing...21 syringes left that have been tampered with..." Resident #4: "...Hydrocodone 5/500...Amount Missing 29 pills..." Resident #5: "...Hydrocodone 5/500 (mg)...Amount Missing 30 pills..." Resident #6: "...Morphine Sulfate 15 mg...Amount Missing 13 pills...Morphine Sulfate 15 mg...Amount Missing 24 pills...Fentanyl 50 mcg (micrograms)...Amount Missing 1 patch...Percocet 10-325 mg...Amount Missing 28 pills...Fentanyl 25 mcg...Amount Missing 2 patches..." Resident #7: "...Oxycodone 10 mg...Amount Missing 28 pills..." Resident #8: "...Hydrocodone 5/500 (mg)...Amount Missing 15 pills..." Review of facility investigation documentation dated November 15, 2011, revealed and signed by the Assistant Director of Nursing (ADON), revealed, "...On 11/7/11 in morning before	F224	F224 MONITORING: Random one on one verbal audits (started 12-27-11) using audit tool to licensed nursing associates of abuse policy, resident property misappropriation will be conducted (10% of associates) weekly times four weeks then monthly thereafter. A Performance Improvement Plan presented to PI Clinical Committee attended by Medical Director, FNP, DON, ED, ADON, Unit Management on 12-30-11.	12-30-11

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F 224	Continued From page 2 morning meeting at 8:45 am (a.m.) I began to enter medication room on new (West) wing (Alleged Perpetrator -AP) was coming out (AP) had narcotic cards in (AP's) hands with controlled substance records (AP) seemed startled...asked (AP) later where (AP) had placed medications (AP) stated they were in (AP's) filing cabinet. I told (AP) they had to go in the doubled locked cabinet (AP) knew. When asked the next day to open the filing cabinet to remove narcotics by myself and the DON (Director of Nursing) (AP) stated, '...don't have my keys.'...instructed to bring keys the next day. We did not see (AP) again." Interview with the ADON on December 1, 2011, at 12:05 p.m., in the conference room, revealed the ADON's written statement dated November 7, 2011, was accurate, the ADON was uncertain when she reported her observation to the Director of Nursing. The ADON stated, "...It was probably the next morning..." Telephone interview with the AP was attempted on December 15, 2011, at 2:08 p.m. and 2:52 p.m. and on December 16, 2011, at 9:30 a.m. and 9:33 a.m., and no contact was made. Interview with the administrator on December 1, 2011, at approximately 10:00 a.m., revealed the residents' medications had been replaced. Interview with the Director of Nursing on December 1, 2011, at 12:00 p.m., in the conference room, revealed the ADON delayed reporting the improperly secured narcotics by the ADON on November 7, 2011, and confirmed the facility had failed to prevent the misappropriation of narcotics for Residents #1-8.	F 224		

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F 224	Continued From page 3 C/O: #28963 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to identify the date and the nurse accepting the physician's order for one resident (#1) and failed to void erroneous prescriptions for two residents (#2, #3) of eleven sampled residents. The findings included: Medical record review of an undated physician's order (Resident #1) revealed no documentation regarding the nurse responsible for receipt of the order and included, "...Oxycod acetomin (oxycodone/acetaminophen) 5/325 1 po q4h prn (by mouth every four hours as needed)..." Interview with the Director of Nursing on December 1, 2011, at 11:28 a.m., in a conference room, confirmed the facility failed to meet accepted standards of practice for Resident #1. Medical record review of a prescription (Resident #2) dated September 15, 2011, revealed both "0" and "5" refills were circled and included, "Percocet 10/325...#240..."	F 224 F 281	F281 CORRECTIVE ACTION: Education was provided to the Nurse Practitioner (12-2-11) when script is written in error i.e.: wrong frequency, doseage, medication or any other plausible error follow process of destruction with script being given back to FNP for her to shred by hand and discard or utilize the facility shred box. Education will be provided to all licensed nursing staff about appropriate signing and dating of physicians orders (Completion date 1-30-12) F281 RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents that have an MD order (including narcotics) are at potential risk. F281 SYSTEMATIC CHANGES: FNP checks script for accuracy, hands off to charge nurse, a double check to be done by charge nurse if errors present hand back script to FNP for proper destruction. (12-2-11)	12-2-11 1-30-12 12-2-11

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F 281	Continued From page 4 Interview with Family Nurse Practitioner (FNP) #1 on December 1, 2011, at 2:25 p.m., in the conference room, revealed the prescription was written in error and confirmed the FNP failed to void the prescription according to accepted standards of practice for Resident #2. Medical record review of a prescription (Resident #3) dated October 28, 2011, revealed, "Oxycodone 2.5/300..." Interview with FNP #1 on December 1, 2011, at 2:20 p.m., in the conference room, revealed Oxycodone was not manufactured in the dosage prescribed on October 28, 2011. Continued interview revealed the prescription was written in error and confirmed the FNP failed to void the prescription according to accepted standards of practice for Resident #3. C/O: #28963	F281	MONITORING: A performance improvement plan will be introduced to the committee (ED, DON, ADON, Unit Management, Medical Director, FNP) on 12-30-2011 that addresses accountability of FNP to accurately write scripts and destroy them if they are written in error as well as proper completion of all orders by licensed nurses. Auditing of scripts from HIM weekly times one month then monthly thereafter as well as daily audit of orders for completion by licensed nursing associates.	12-30-11
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F425	CORRECTIVE ACTION: 1) When prn narcotic medications are not used within a 90 day time frame, DON or designee ADON, LPN, RN Unit Managers, will obtain a discontinue use order and timely destruction of medications should be performed by an RN and facility consultant pharmacist per established policy and procedure: store behind double lock until destruction, dispose of wasted meds and record disposal quantity, date of destruction, record signature of registered nurse and pharmacist. 2) Education to all Licensed Nurses re: appropriate way to complete resident orders including, date, time, nurse signature, read back and verify. HIM reviewing all orders for errors daily.	

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F 425	Continued From page 5 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on review of the pharmacy consultant contract, facility pharmacy policy, review of facility investigation documentation, medical record review, observation, and interview, the facility failed to provide pharmceutical services to assure the accurate acquiring, receiving, dispensing, administering, and disposition of controlled drugs for six residents (#1, #2, #3, #5, #10, #11) of eleven sampled residents. The findings included: Review of the "Pharmacy Consultant Agreement" dated October 1, 1999, revealed, "...Consultant will...Provide general supervision of the FACILITY'S procedures for the control and accountability of all drugs...to better ensure that the FACILITY'S policies and procedures are in compliance with applicable local, state and federal laws and regulations...Ensure that FACILITY remains in compliance with any and all state and/or federally mandated survey requirements..." Review of the facility pharmacy's policy "...Medication Disposal/Destruction of Expired or Discontinued Drugs" effective December 12,	F 425	3) FNP provided educational training when writing script address quantity of med as opposed to refill. 4) Education (12-2-11) provided to FNP to address proper process to destroy script. New process for FNP to always take scripts written in error back in her possession for destruction. 5) All discontinued narcotic orders are read in morning clinical meeting and the Unit Manager, DON, ADON will be responsible for storing narcotics behind double lock storage after they obtained from the charge nurse on the hall. Discontinued orders will be compared with all narcotics removed from the narcotic drawer of the med cart that all discontinued meds are accounted for. Pharmacist at monthly visits will along with facility designee destroy narcotics. Narcotic Sheets will be audited for non use through a biweekly audit of prn narcotic medications. Audited for use and if not used in 90 days discontinue and remove from medication cart and place behind double lock door for storage awaiting destruction. F425 RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents have the potential to be affected by these issues.	12-2-11

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F 425	Continued From page 6 2007, revealed,"...Facility staff should destroy and dispose of medications in accordance with Facility Policy and Applicable Law...Once an order to discontinue a medication is received, the Facility staff is to remove this medication from the resident's drug supply...Discontinued medications...will be disposed of by the facility staff within 90 days of the date the medication was discontinued by the prescriber...Controlled substances may not be returned to the Pharmacy...Before destruction the facility secures controlled substances under double lock at all times...Wasted meds are defined as medication contaminated or refused that require disposal...Wasted controlled meds are destroyed by two licensed nurses employed by the facility...applies to the disposal of...unused...doses of controlled substances...wasted for any reason..." Medical record review of an undated physician's order (Resident #1) revealed no documentation regarding the nurse responsible for receipt of the order and included, "...Oxycod acetomin (oxycodone/acetaminophen) 5/325 1 po q4h prn (by mouth every four hours as needed)..." Medical record review of a Medication Administration Record dated October, 2011, revealed the medication was administered on October 10, 16, 23, and 24, 2011. Medical record review of a prescription (Resident #2) dated September 15, 2011, revealed both "0" and "5" refills were circled, the prescription had not been voided, and included, "Percocet 10/325..." Medical record review of a prescription (Resident	F425	SYSTEMATIC CHANGES: When prn narcotic medications are not used within a 90 day time frame a discontinue use order will be obtained and timely destruction of medications will be performed by an RN and facility consultant pharmacist per established policy and procedure. HIM reviewing all orders for errors daily. Education provided to FNP to address proper process to destroy script. New process for FNP to always take scripts written in error back in her possession for destruction. All discontinued narcotic orders are read in morning clinical meeting and the Unit Manager, DON, ADON and charge nurse from floor will be responsible for conducting a weekly audit so all discontinued narcotics are accounted for and stored behind double lock storage. Pharmacy at monthly visits will along with facility designee destroy narcotics. Narcotic Sheets will be audited for non use through a biweekly audit of prn narcotic medications by the DON or designee ADON, ED, Unit Managers LPN and RN 12-30-11. Audited for use and if not used in 90 days discontinue and remove from medication cart and place behind double lock door for storage awaiting destruction.	12-30-11

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F 425	Continued From page 7 #3) dated October 28, 2011, revealed, "Oxycodone 2.5/300..." Continued review revealed the prescription had not been voided. Interview with the Family Nurse Practitioner on December 1, 2011, at 2:20 p.m., in a conference room, revealed the prescription had not been voided as of December 1, 2011. Interview with the Director of Nursing (DON) on December 1, 2011, at 2:12 p.m., in the conference room, revealed the facility's practice to void a prescription was to write "void" on a prescription or an "x" through a prescription. Interview with the DON on December 1, 2011, revealed pharmacy reviews were completed monthly. Medical record review of a physician's order (Resident #5) dated September 12, 2011, revealed, "Change Lortab to 2.5/500 every 4 hours while away. continue to have available Lortab 5/500 every 6 hours PRN (as needed)." Telephone interview with Facility Pharmacist #1 on December 14, 2011, at 12:25 p.m., revealed the order required clarification. Review of facility investigation documentation dated November 15, 2011, revealed, "...(Resident #10) had a card of Ultram (a narcotic pain medication) in the West...med cart...The resident did not even have an order on the current November MAR (medication administration record)...did not have an order on there for as far back as August 2011." Medical record review of a physician's order	F425 MONITORING: A performance improvement plan addressing the process for narcotic handling after discontinuation and destruction time frame will be presented to PI committee attended by DON, ED, ADON, Unit Management, Medical Director and FNP.	

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F 425	Continued From page 8 (Resident #10) dated January 5, 2011, revealed, "Ultram 50 (milligrams) po q6h prn (by mouth every six hours as needed)." Medical record review of a physician's order dated March 3, 2011, revealed, "...Stop Ultram..." Observation with the Director of Nursing and Administrator on December 1, 2011, at approximately 3:30 p.m., in a conference room, revealed a card of Ultram 50 milligram tablets contained twenty-eight pills, and included, "(Resident #10)...1/06/11..." Interview with the Director of Nursing on December 2, 2011, at 12:30 p.m., in the conference room, revealed the medication was located in a medication cart on December 1, 2011. Interview with the administrator on December 13, 2011, at 1:20 p.m., revealed medication carts were audited quarterly by the pharmacy and she stated, "...pharmacy tech (technician) does an exhaustive audit of med carts..." Telephone interview with the facility's pharmacy consultant on December 14, 2011, revealed, "...Extender (pharmacy tech) should find if prn (as needed medication) in cart and not used and report to nursing..." Review of the most recent pharmacy tech report provided by the facility on December 13, 2011, and dated March 18, 2011, revealed no documentation regarding Ultram. Review of facility policy revealed, "Controlled	F 425		

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F 425	Continued From page 9 Drugs...Appropriate storage...always maintained on all units...The nurse has two keys: one key for controlled drugs...nursing medications keys are not to be given to unlicensed personnel." Observation of a West wing controlled drug count with Licensed Practical Nurse (LPN) #1 and the Assistant Director of Nursing (ADON) on December 13, 2011, at 2:00 p.m., revealed a Lorazepam 0.5 mg. (a controlled medication) was missing from a card of controlled medications (Resident #11) and located in the narcotic drawer of the medication cart. Continued observation revealed the ADON placed the Lorazepam in a single-lock sharps container attached to the medication cart. Interview with the ADON on December 13, 2011, at approximately 2:07 p.m., at the West wing nurse's station, revealed wasting controlled drugs in a single lock sharps container was the usual practice at the facility. Interview with Registered Nurse (RN) #1 on December 13, 2011, at 2:45 p.m., at the West wing nurse's station revealed RN #1 did not have a key to the sharps container. Continued interview revealed housekeeping had keys to unlock the sharps container. Observation and interview with Housekeeper #1 on December 13, 2011, at 2:47 p.m, revealed the housekeeper opened the single-lock sharps container with a key and housekeepers disposed of filled sharps containers (including wasted controlled drugs) in biohazard bags as needed. Telephone interview with the facility's Consultant	F 425		

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F 425	Continued From page 10 Pharmacist on December 14, 2011, at 12:55 p.m., revealed it could take up to thirty days to fill a sharps container and he stated, "...perfectly acceptable to dispose of controlled meds in a single-lock sharps container." Continued interview confirmed the pharmacy had failed to implement pharmacy policies and/or establish a system to account for and/or maintain required storage of all controlled drugs.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F431 CORRECTIVE ACTION: Tracking of all prn narcotics will be done by DON or designee of ADON, ED (RN) or Unit Managers (LPN, RN) by checking for non usage of prn narcotic medications. Facility wastes narcotics as per pharmaceutical guidelines: dispose of wasted meds with a witness of two licensed nurses, record of disposal quantity, date of the disposal, signature of two licensed nurses in proper disposal receptacle.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 11 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on review of the pharmacy contract, facility pharmacy policy, review of facility investigation documentation, medical record review, observation, and interview, the facility failed to provide pharmacy services to ensure timely disposal of discontinued controlled medication for one resident (#10) and double lock storage and/or wasted controlled medication(s) for one residents (#11) of eleven sampled residents. The findings included: Review of the "Pharmacy Services Agreement" dated August 11, 1999, revealed, "...The FACILITY is engaged in the operation of a nursing facility, for which it requires pharmacy services in accordance with applicable local, state, and federal laws and regulations...The PHARMACY is... capable of providing pharmaceutical dispensing and distribution services...Ensure that FACILITY at all times remains in compliance with any and all...federally mandated survey requirements as they relate to medication administration..." Review of the facility pharmacy's policy "...Medication Disposal/Destruction of Expired or	F431 RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents with narcotic agents ordered are at a potential risk. PRN narcotics will be monitored and when non-usage determined they will be removed for destruction from medication cart in a timely manner. F431 SYSTEMATIC CHANGES: Tracking of all prn medications biweekly and as needed by DON or designee: ADON, Unit Management. PRN narcotic sheets will be checked for non-usage of these medications. The facility follows pharmaceutical guidelines for wasting of narcotics: dispose of wasted meds with a witness of two licensed nurses, record of disposal quantity, date of the disposal, signature of two licensed nurses in proper disposal receptacle. Education provided to licensed nursing staff to never waste any amount of narcotic in a sharps container 1-13-12.	1-13-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445314	A. BUILDING _____ B. WING _____	C 12/19/2011

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F 431	Continued From page 12 Discontinued Drugs" effective December 12, 2007, revealed,"...Facility staff should destroy and dispose of medications in accordance with Facility Policy and Applicable Law...Discontinued medications...will be disposed of by the facility staff within 90 days of the date the medication was discontinued by the prescriber...Controlled substances may not be returned to the Pharmacy...Before destruction the facility secures controlled substances under double lock at all times...Wasted meds are defined as medication contaminated or refused that require disposal...Wasted controlled meds are destroyed by two licensed nurses employed by the facility...applies to the disposal of...unused...doses of controlled substances...wasted for any reason..." Review of facility investigation documentation dated November 15, 2011, revealed, "...(Resident #10) had a card of Ultram (a narcotic pain medication) in the West...med cart...The resident did not even have an order on the current November MAR (medication administration record)...did not have an order on there for as far back as August 2011." Review of facility policy revealed, "Controlled Drugs...Appropriate storage...always maintained on all units...The nurse has two keys: one key for controlled drugs...nursing medications keys are not to be given to unlicensed personnel." Observation of a West wing controlled drug count with Licensed Practical Nurse (LPN) #1 and the Assistant Director of Nursing (ADON) on December 13, 2011, at 2:00 p.m., revealed a Lorazepam 0.5 mg. (a controlled medication) was	F431 MONITORING: A Performance Improvement Plan to ensure audit of prn narcotic usage and completion of education to never waste a narcotic in a sharps container will be presented to the PI clinical committee (Medical Director, ED, DON, ADON, Unit Managers, FNP) on 12-30-11.	12-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 13 missing from a card of controlled medications (Resident #11). Continued observation revealed the medication was located in the narcotic drawer of the medication cartand the ADON placed the Lorazepam in a single-lock sharps container attached to the medication cart. Interview with the ADON on December 13, 2011, at approximately 2:07 p.m., at the West wing nurse's station, revealed wasting controlled drugs in a single lock sharps container was the usual practice at the facility. Interview with Registered Nurse (RN) #1 on December 13, 2011, at 2:45 p.m., at the West wing nurse's station revealed RN #1 did not have a key to the sharps container. Continued interview revealed housekeeping had keys to unlock the sharps container. Observation and interview with Housekeeper #1 on December 13, 2011, at 2:47 p.m, revealed the housekeeper opened the single-lock sharps container with a key and housekeepers disposed of filled sharps containers (including wasted controlled drugs) in biohazard bags as needed. Telephone interview with the facility's Consultant Pharmacist on December 14, 2011, at 12:55 p.m., revealed it could take up to thirty days to fill a sharps container (including wasted controlled drugs) and confirmed the pharmacy had failed to implement pharmacy policies regarding double lock storage and waste of controlled drugs.	F 431		